Singulair (montelukast)
Prior Authorization Request Form

5655

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) TRICARE pharmacy program (TPHARM). Express Scripts is the TPHARM contractor for DoD.

MAIL ORDER and RETAIL	• The provider may **call**: **1-866-684-4488** or the completed form may be **faxed** to: **1-866-684-4477** • The patient may attach the completed form to the prescription and **mail** it to: **Express Scripts, P.O. Box 52150, Phoenix, AZ 85072-9954** or **email** the form only to: **TpharmPA@express-scripts.com**

Prior authorization criteria and a copy of this form are available at **http://pec.ha.osd.mil/forms_criteria.php**. This prior authorization has no expiration date.

Step 1

Please complete patient and physician information (please print):

Patient Name: _____ Physician Name: _____

Address: _____ Address: _____

_____ _____

Sponsor ID # _____ Phone #: _____

Date of Birth: Secure Fax #:

Step 2

1. Please indicate the diagnosis or indication for which Singulair is being prescribed:

☐ Asthma	Go to **Section 1 below**
☐ Seasonal allergic rhinitis	Go to **Section 2 on Page 2**
☐ Perennial allergic rhinitis	**Coverage not approved**
☐ Asthma **AND** seasonal allergic rhinitis	Go to **Section 3 on Page 2**
☐ Asthma **AND** perennial allergic rhinitis	Go to **Section 1 below**
☐ Nasal polyposis	Go to **Section 2 on Page 2**
☐ Other indication or diagnosis than listed above	**Coverage not approved**

Section 1 – Diagnosis of Asthma (with or without perennial allergic rhinitis)

1. Has the patient tried an oral inhaled corticosteroid or has a contraindication to an oral inhaler corticosteroid?	☐ Yes **Proceed to Step 3** on the bottom of page 2	☐ No **Coverage not approved**

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Section 2 – Diagnosis of Seasonal Allergic Rhinitis or Nasal Polyposis

1. Has the patient tried and had an inadequate response to a nasal corticosteroid within the previous 6 months?	☐ Yes **Proceed to Step 3 below**	☐ No **Proceed to Question 2**
2. Has the patient tried and experienced an intolerance (due to adverse events) to a nasal corticosteroid?	☐ Yes **Proceed to Step 3 below**	☐ No **Proceed to Question 3**
3. Does the patient have a contraindication to use of a nasal corticosteroid?	☐ Yes **Proceed to Step 3 below**	☐ No **Coverage not approved**

Section 3 – Diagnosis of Asthma AND Seasonal Allergic Rhinitis

1. Has the patient tried an oral inhaled corticosteroid or has a contraindication to an oral inhaled corticosteroid?	☐ Yes **Proceed to Step 3 below**	☐ No **Proceed to Question 2**
2. Has the patient tried and had an inadequate response to a nasal corticosteroid within the previous 6 months?	☐ Yes **Proceed to Step 3 below**	☐ No **Proceed to Question 3**
3. Has the patient tried and experienced an intolerance (due to adverse events) to a nasal corticosteroid?	☐ Yes **Proceed to Step 3 below**	☐ No **Proceed to Question 4**
4. Does the patient have a contraindication to use of a nasal corticosteroid?	☐ Yes **Proceed to Step 3 below**	☐ No **Coverage not approved**

Step 3

I certify the above is correct and accurate to the best of my knowledge. Please sign and date:

Prescriber signature _____ Date _____

Implemented 1 Feb 2012